

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CHARLES HENRY ADAMS Jr.				2a. DATE OF DEATH MONTH DAY YEAR February 18, 1984			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1942		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 41	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Drayden, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic		12b. KIND OF BUSINESS OR INDUSTRY Tech.	
13a. STATE Maryland				13b. CITY OR TOWN St. Mary's Valley Lee		13c. STREET ADDRESS / ZIP CODE P.O. Box 83 20692	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Henry Adams Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Delozier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 214-42-5107		17. INFORMANT ADDRESS Patricia Adams same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs. 6 mo. 2 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-17-84 to 2-18-84 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 2-17-84 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE J. Patrick Jarboe, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Leonardtwn, Md. 20650					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/21/84		23c. NAME OF CEMETERY OR CREMATORY St. George Catholic		23d. LOCATION CITY OR TOWN COUNTY STATE Valley Lee St. Mary's Md.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				25a. DATE REC'D. BY REGISTRAR FEB 22 1984			
ADDRESS Leonardtwn, Md.				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

DHAM-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

05638

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOUIS Robert BENSON			2a. DATE OF DEATH MONTH DAY YEAR 02 - 29-1984		2b. HOUR p.m. 1300
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 12 13 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10. CITY OR TOWN OF DEATH Patuxent River	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Naval Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY High School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY St. Marys	13c. CITY OR TOWN Mechanicsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS RT 2, PO Box 16 20659	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Benson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Grudin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 093-14-2963		17. INFORMANT ADDRESS George Sullivan Mechanicsville, Md. 20659	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Stomach DUE TO, OR AS A CONSEQUENCE OF (c) Obstructed bowel as a result of (b) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>D. S. Welch</i> DEGREE				22c. DATE SIGNED 29 Feb 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. S. WELCH, CAPT, MC, USNR			22e. ADDRESS Naval Hospital, Patuxent River, MD 20670		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Mar. 2, 1984	23c. NAME OF CEMETERY OR CREMATORY Arlington National Arlington Va.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley ADDRESS Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR MAR 5 1984		

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1- FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
FLORENCE LILLIAN COLBERT			February 12, 1984		6:30 P.M.	
3 SEX		4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White	Nov. 20, 1904		79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Mass.		U.S.A.			St. Mary's County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Leonardtown		St. Mary's Hospital		Retired		Secretary
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland		St. Mary's	Ridge	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Gen. Del. 20680	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
Frederick Davis			Delphine DeLisle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No			578-28-8034		63 Cross Street Foxboro, Mass.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4292 Chronic lung disease						
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
		HOUR A.M. MONTH DAY YEAR				
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1980, 19, to 2-12-84, 19, that (I) (we) lost saw the deceased alive on 2/11/84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		2/3/84		
William D. Boyd, II, M.D.		Leonardtown, Md. 20650				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		Feb. 25, 1984		4 Westville Cem.		CITY OR TOWN COUNTY STATE
						Taunton Bristol Mass.
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
W. Clarke Mattingley Leonardtown, Md.				FEB 23 1984		

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February 12, 1981

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St. Mary's County

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

05640

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lue Odate Dailey			2a. DATE OF DEATH MONTH DAY YEAR February 6, 1984			2b. HOUR M		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.		
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY St. Mary's		13c. CITY OR TOWN Leonardtwn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 27A 20650								
14. FATHER'S NAME FIRST MIDDLE LAST Louis Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Gross				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-16-4501		17. INFORMANT Leona Walton				
17. ADDRESS same as 13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unstable Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1982</u> , 19____, to <u>2/6/84</u> , 19____, that (I) (we) lost saw the deceased alive on <u>2/2/84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>William D. Boyd</u> DEGREE				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd M.D.				22e. ADDRESS Leonardtwn, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 10 '84		23c. NAME OF CEMETERY OR CREMATORY St. Mark's		23d. LOCATION CITY OR TOWN COUNTY STATE Valley Lee St. Marys Md.		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				25a. DATE REC'D. BY REGISTRAR FEB 14 1984				
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>								

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

05641

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FREDERICK LEE DAVIS, JR			2a. DATE OF DEATH MONTH DAY YEAR February 27, 1984		2b. HOUR 12:26A_M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 30, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10. CITY OR TOWN OF DEATH Leonardtwn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil service		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY St Mary's	13c. CITY OR TOWN Hollywood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Route 2, Box 87 20636
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Lee Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Ann Cheseldine		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes AF		16b. SOCIAL SECURITY NO. 1950-1054		17. INFORMANT Lauretta T. Davis Same as # 13 above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1539

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE NOT WHILE
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/27 1984, to 2/27 1984, that (I) (we) last saw the deceased alive on 2/27 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Youngsik Moon, M. D.

22e. ADDRESS

Hollywood, Maryland 20636

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

2/29/1984

23c. NAME OF CEMETERY OR CREMATORY

St Johns

23d. LOCATION
CITY OR TOWN

Hollywood, St. Mary's, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

W. Clarke Mattingley Leonardtown, Maryland

25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

FEB 28 1984 Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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February 27, 1951

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February 27, 1951

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February 27, 1951

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

05642

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOUIS T. DENT			2a. DATE OF DEATH MONTH DAY YEAR February 19, 1984		2b. HOUR 11:59^{P.}_{M.}
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10-05-09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10. CITY OR TOWN OF DEATH Leonardtwn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe-fitter	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Calvert Lusby			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13c. STREET ADDRESS / ZIP CODE Box 1-F 20657			14. FATHER'S NAME FIRST MIDDLE LAST Louis T. Dent, Sr.		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie R. Weems			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		
16b. SOCIAL SECURITY NO. 220-09-6933			17. INFORMANT ADDRESS Eliza Dent Box 1-F, Lusby, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebro-Vascular Accident (c) Coronary artery Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Hypertension Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF FIFTH, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/15 , 19 84 , to 2/19 , 19 84 , that (I) (we) lost saw the deceased alive on 2/19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Adinath Patil		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adinath Patil, M. D.		22e. ADDRESS Leonardtwn, Maryland 20650			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 23-84	23c. NAME OF CEMETERY OR CREMATORY St. Johns Chr. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Lusby Calvert Md	
24. FUNERAL DIRECTOR NAME Spencer E. Sewell		ADDRESS Box 31, Prince Frederick, Md		15a. DATE RECD. BY REGISTRAR 15b. REGISTRAR'S SIGNATURE Feb 21 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retain for the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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February 18, 1981

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

05643

1. DECEASED NAME (TYPE OR PRINT) PETER ROGER GRAVES			2a. DATE OF DEATH MONTH DAY YEAR February 3, 1984			2b. HOUR 10:00P M					
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2/13/1916		6. AGE (IN YEARS LAST BIRTHDAY) 67		7. IF UNDER 1 YEAR MONTHS DAYS YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.					
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (OCCUPATION OR INDUSTRY AT DEATH) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY LUMBER CO.			
13a. STATE MD.			13b. COUNTY ST MARY'S		13c. CITY OR TOWN LEX. PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. 235 20653		
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS B. GRAVES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY A. DOWNS				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II		16b. SOCIAL SECURITY NO. 214-12-7503	
17. INFORMANT ADDRESS GEN. DEL.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4589 Acute Respiratory arrest with hypotension DUE TO, OR AS A CONSEQUENCE OF (b) Cachexia related to Nutritional deficiency DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Severe Esophageal stricture + Pulmonary infection											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James C. Boyd, M. D.			DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/4/84			
22d. PHYSICIAN'S NAME (LINE ON PRINT)			22e. ADDRESS Leonardtwn, Maryland 20650								
23a. BURIAL OR CREMATION REMOVAL (SPECIFY) BURIAL			23b. DATE 2/07/84			23c. NAME OF CEMETERY OR CREMATORY CHELTENHAM VET. CEME			23d. LOCATION CHELTENHAM COUNTY STATE P.G. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS W.C. MATTINGLEY, LEONARDTOWN, MD. 20650						25a. DATE REC'D. BY REGISTRAR FEB 10 1984		25b. REGISTRAR'S SIGNATURE John J. Carver			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100:00 100:00 100:00 100:00

St. Mary's County

John J. ...

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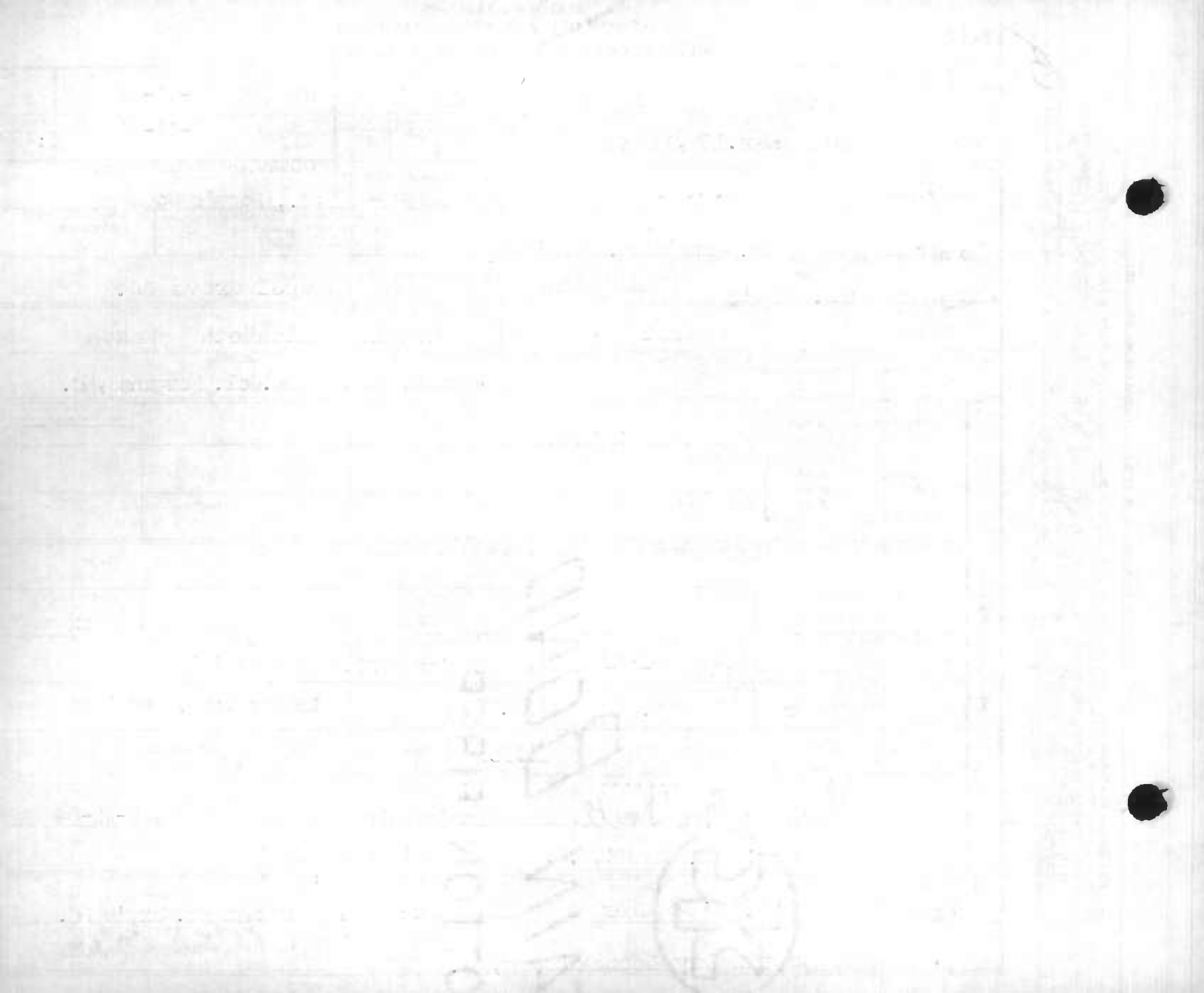
John J. ...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201. BRING TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 0 5 6 4 4 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JAMES PATRICK HOLT						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 2-11-84		2b. HOUR 19		2c. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input type="checkbox"/> 2-11-84		2d. HOUR 19	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH Mar. 17, 1948		6. AGE (IN YEARS) 35		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. DATE PRONOUNCED DEAD 2-11-84		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County	
10. CITY OR TOWN OF DEATH Leonardtown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farming				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. CITY OR TOWN St. Mary's		13c. CITY OR TOWN Morganza		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Laurel Grove Rd. 20660			
14. FATHER'S NAME John Holt						15. MOTHER'S MAIDEN NAME Carrie Elizabeth Mason							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Arcadia Holt gen. del. Morganza, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8147 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 6:21 PM 2-11-84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by a vehicle					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hgw. Rt. 5				21f. LOCATION Leonardtown, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion depth resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Margarita A. Korell						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 17 '84		23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens				23d. LOCATION CITY OR TOWN Leonardtown COUNTY St. Mary's STATE Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley ADDRESS Leonardtown, Md.						25a. DATE REC'D. BY REGISTRAR FEB 17 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell							

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the medical examiner's office. Pages 3 and 4 should be filed with the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the medical examiner's office. Page 3 should be filed with the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the office.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) MILDRED MAY JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR February 13, 1983			2b. HOUR 1:18A.M.		
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 2, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.					
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Lexington Park NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE Center Gardens Apartments 20653			
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Phillips				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nan Collins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-16-2099		17. INFORMANT Ingrett Hoopengardner				ADDRESS Rt. 3 Box 698 Hollywood, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiopulmonary Collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause: (a), stating the underlying cause last (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes hrs.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO IMMEDIATE DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19b OR PART 2)			
21a. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21c. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I did <input checked="" type="checkbox"/> did not <input type="checkbox"/>) attended the deceased from 2/13/84 to 2/13/84 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I did <input checked="" type="checkbox"/> did not <input type="checkbox"/> view the body after death.)											
22b. SIGNATURE J. Patrick Jarboe, M.D.				22c. ADDRESS Leonardtwn, Md. 20650				22d. DATE SIGNED 2/14/84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 15 '84		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lexington Park St. Marys Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn, Md.				25a. DATE REC'D. BY REGISTRAR FEB 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell	

BP.

2. *How many people are there in your family?*

Dr. Mary E. Thompson

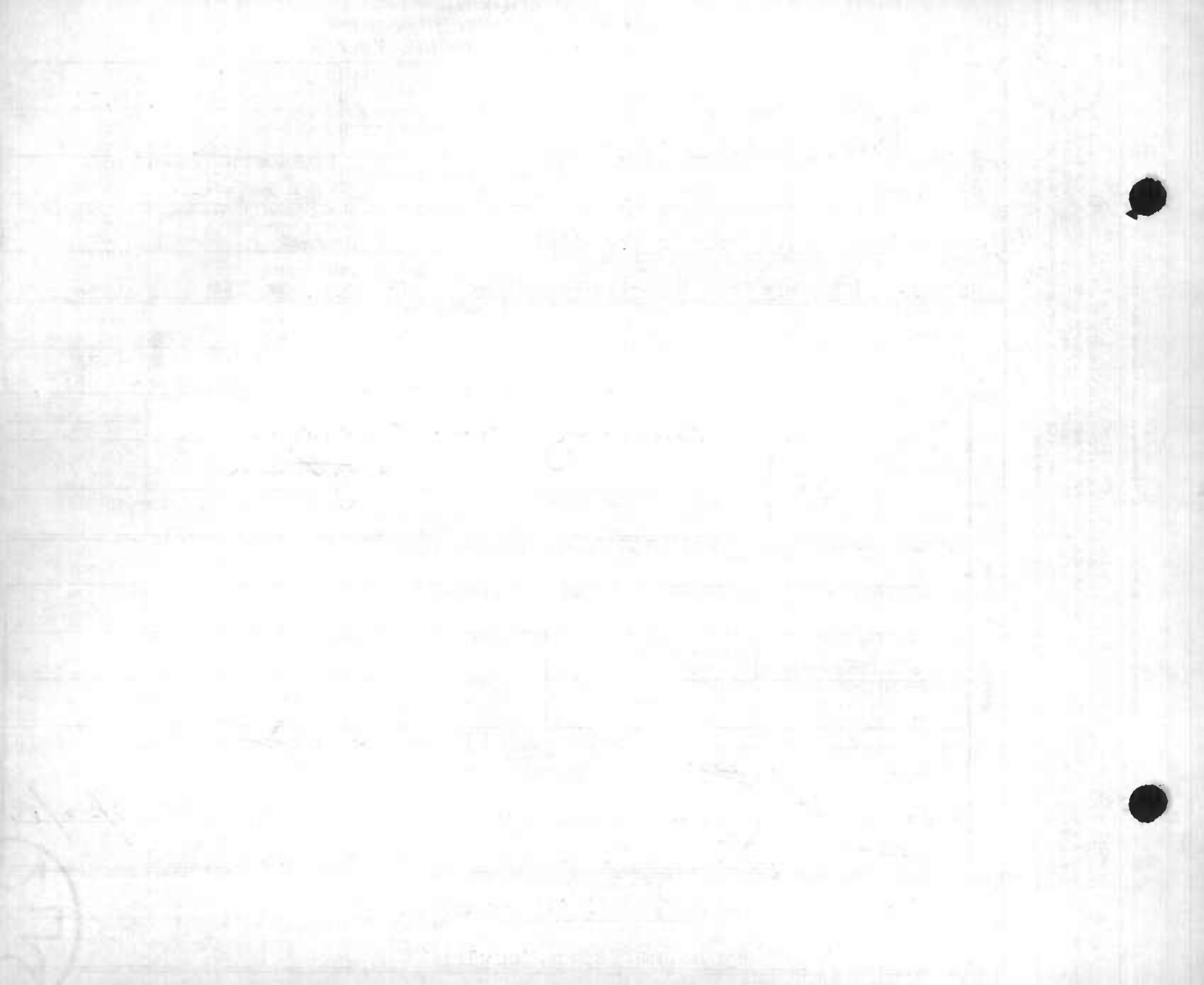
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(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) BERNARD NICHOLAS RIDGELY						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> Feb. 19, 1984		2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 13, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD Feb. 19, 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St Mary's MD.					
10. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farner		12b. KIND OF BUSINESS OR INDUSTRY Self			
13a. STATE Maryland		13b. COUNTY St Mary's		13c. CITY OR TOWN Mechanicsville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 164 20659			
14. FATHER'S NAME FIRST MIDDLE LAST Charles E Ridgley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Jennie Sweeney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW 1		17. INFORMANT Marion R. Chesley		ADDRESS Box 73 Charlotte Hall, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & cardiac arrhythmia 5140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James C. Boyd				M.D. M. D.				MEDICAL EXAMINER		DATE SIGNED 2/22/84	
EXAMINER'S NAME (TYPE OR PRINT) James C. Boyd M. D.				ADDRESS Leonardtwn, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 22, 1984		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley Leonardtown, Maryland						25a. DATE REC'D. BY REGISTRAR FEB 24 1984		25b. REGISTRAR'S SIGNATURE Davidson-Hendell			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) John W. Scales			2a. DATE OF DEATH Month 2 Day 29 Year 89			2b. HOUR 12:40 P.M.					
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH Nov. 2, 1894		6. AGE (In years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH St. Marys Md.					
10. CITY OR TOWN OF DEATH Lexington Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Amber House			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Calvert		13c. CITY OR TOWN Huntingtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 192 20639		
14. FATHER'S NAME John W. Scales, Sr.			15. MOTHER'S MAIDEN NAME Sarah Gross								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 215-26-0705		17. INFORMANT Mary Washington			Address Box 192, Huntingtown, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Organic Brain Syndrome</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/21/89</u> , 19 <u>89</u> , to <u>2/29/89</u> , 19 <u>89</u> , that (I) (we) last saw the deceased alive on <u>2/21/89</u> , 19 <u>89</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David C. Allen						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/29/89	
22d. PHYSICIAN'S NAME (Type) DAVID C. ALLEN						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Mar. 5-1984		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Chr. Cemetery				23d. LOCATION (City or Town) (County) (State) Prince Frederick, Md			
24. FUNERAL DIRECTOR Spencer E. Sewell						ADDRESS Box 31, Prince Frederick, Md		25. REGISTRAR'S SIGNATURE MAR 00 1989			

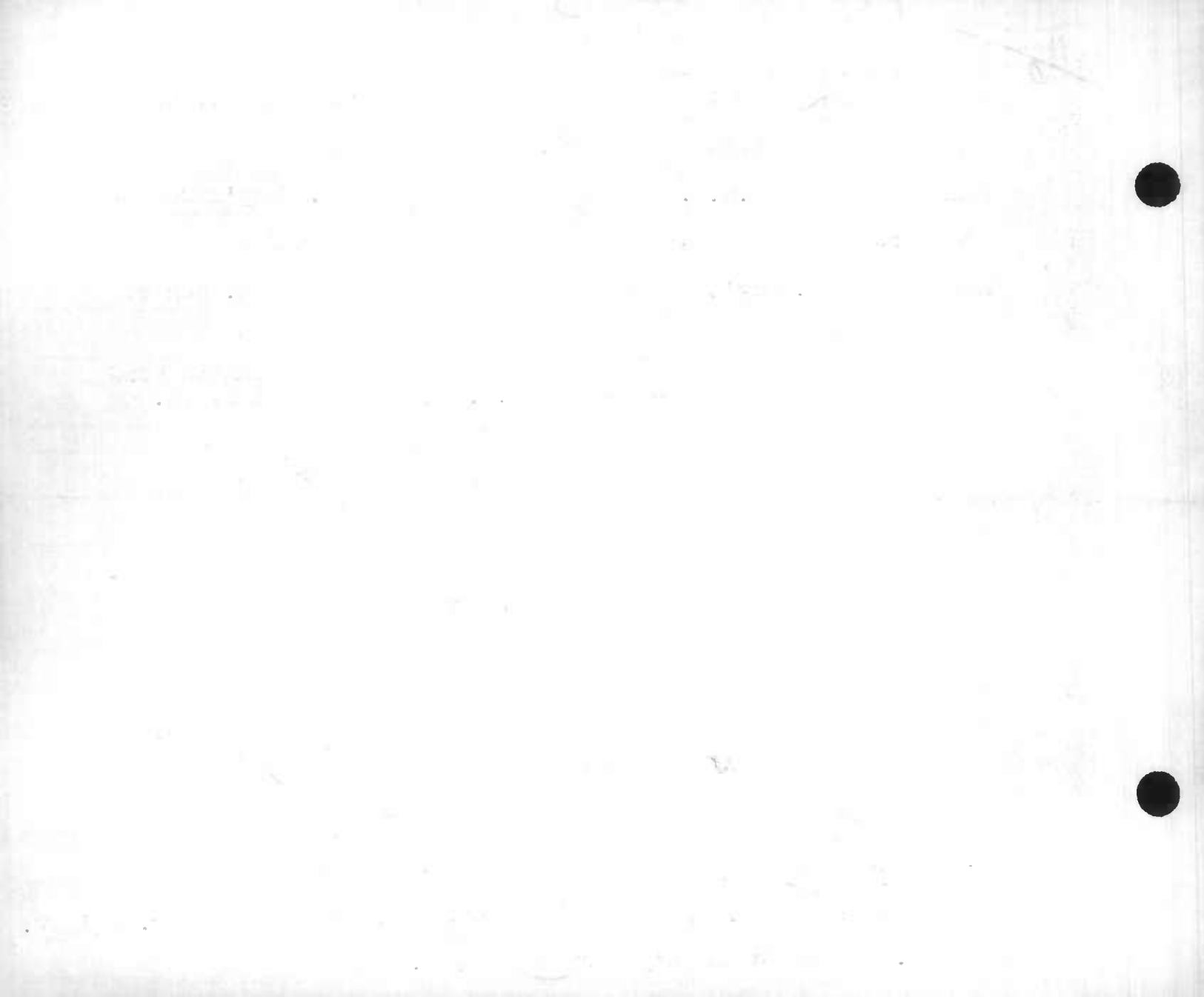
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as "not shown" any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

05648

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
Mary Erwin Louise Shore		February 18, 1984		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	NOV. 1, 1915	68	MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	U.S.A.		St. Mary's County MD.		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Chaptico	at home		Housewife		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b CITY OR TOWN	13c STREET ADDRESS / ZIP CODE		
Maryland		St. Mary's	Chaptico	Star Rt. Box 84 20621	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
? MIDDLE LAST		? MIDDLE LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS		
		538-03-8472D	190 Mountain Road Powhatan, Va.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart failure + cardiac 4280 DUE TO, OR AS A CONSEQUENCE OF (b) anything (c) DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 84 to 2/18 19 84, that (I) (we) last saw the deceased alive on 2/18 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE James C. Boyd M.D.		22c DATE SIGNED	
22b SIGNATURE		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22b SIGNATURE		22e ADDRESS Leonardtown, Maryland			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE
Burial		Feb. 22, 1984	Charles Memorial Gardens		Leonardtown St. Mary's Md.
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
W. Clarke Mattingley		MAR 1 1984			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Deborah Ann Simmons (Nee Stojka)										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Feb. 18, '84	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 15, 1956		6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR 3:00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Feb. 18, 1984	
10. CITY OR TOWN OF DEATH Clements				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Leonardtwn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 2 Box 137 20650			
14. FATHER'S NAME FIRST MIDDLE LAST John Stojka				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Sylvia Dwyer				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
17. SOCIAL SECURITY NO. 220-78-4384				17. INFORMANT David Simmons				17. ADDRESS same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Gun Shot Wound to Chest (Suicide) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Depression (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY)	
ACTUAL SIGNATURE James E. Boyd MD.				M.D. _____				MEDICAL EXAMINER DATE SIGNED 2/20/84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS P.O. Box 301 Dec. md							
23a. BURIAL, CREMATION, REMOVAL, ETC. DATE (SPECIFY) Burial Feb. 21, '84				23c. NAME OF CEMETERY OR CREMATORY Christ Episcopal Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Chaptico St. Mary's Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn, Md.				25a. DATE REC'D. BY REGISTRAR FEB 22 1984			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

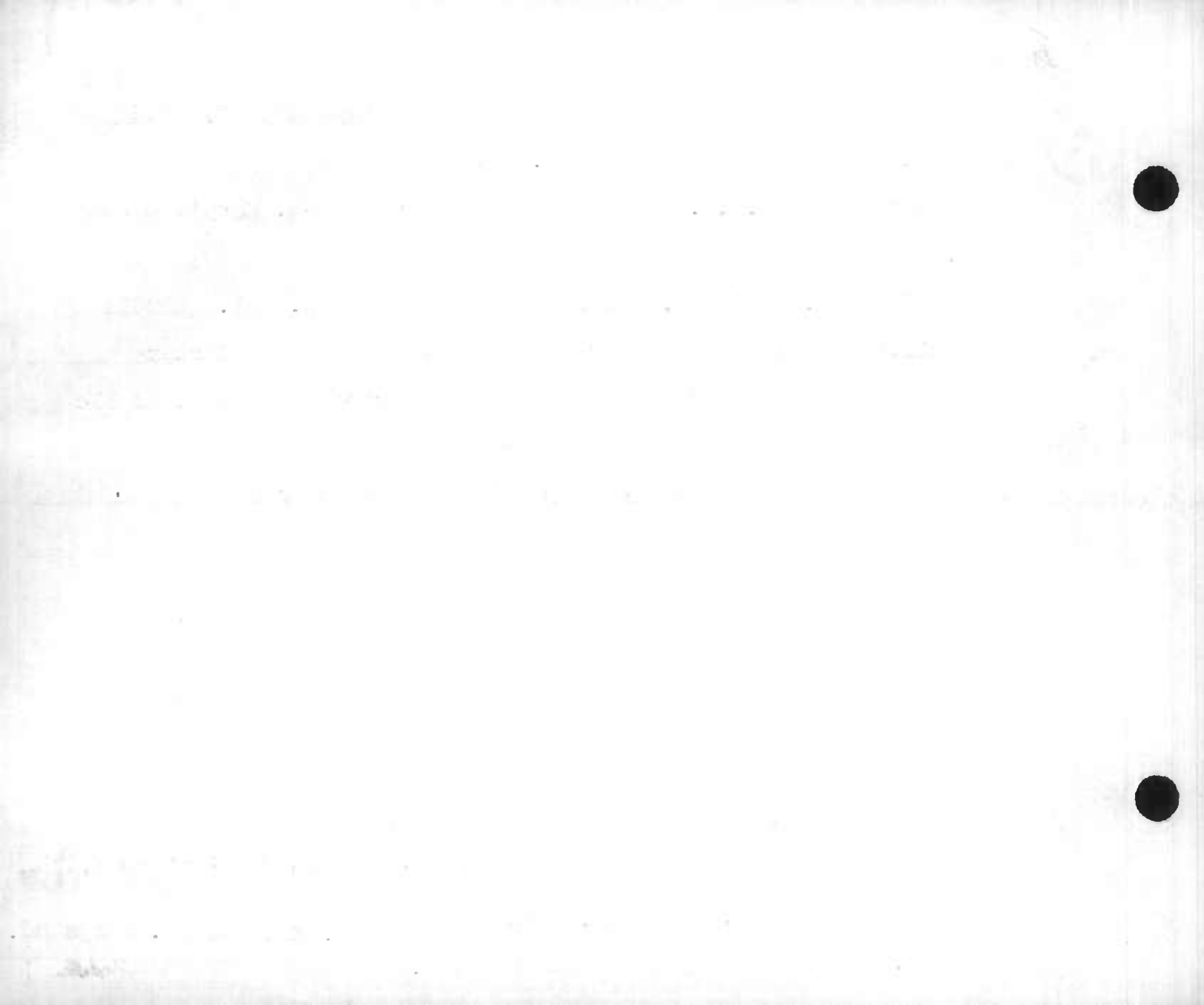
IMPORTANT: If item 21 is marked as 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Elmer Smallwood			2a. DATE OF DEATH MONTH DAY YEAR February 28, 1984			2b. HOUR M					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.					
10. CITY OR TOWN OF DEATH St. Inigoes		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY St. Mary's		13c. CITY OR TOWN St. Inigoes		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Gen. Del. 20684		
14. FATHER'S NAME FIRST MIDDLE LAST William Tiny Smallwood				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Carter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-14-3451		17. INFORMANT JoAnn Smallwood				ADDRESS same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca Esophagus</u> 1509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIO RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE GK Shah MD						DEGREE MD			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G MED- K SHAH MD						22e. ADDRESS P.O. Box 442, LEONARDTOWN MD 20650					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 3, 1984		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE St. Inigoes St. Marys Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley						25a. DATE REC'D. BY REGISTRAR MAR 5 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MARY CLAIRE STASO						2a. DATE OF DEATH MONTH DAY YEAR February 19, 1984				2b. HOUR 01:00AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 18 84		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 52		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.					
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland St. Mary's				13b. CITY OR TOWN Lexington Park		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE P.O. Box 367 20653			
14. FATHER'S NAME FIRST MIDDLE LAST David Alan Staso				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathy Ann Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS David A. Staso				Same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity (24wk. gestation) 7650 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-18-84 , 19____, to 2-19-84 , 19____, that (I) (we) lost saw the deceased alive on 2-19-84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Susanne S. Ashton, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susanne S. Ashton, M.D.				22e. ADDRESS Loveville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 20 '84		23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtown St. Mary's Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtown, Md.				25a. DATE REC'D. BY REGISTRAR MAR 19 1984			
				25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>							

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles William Taylor			2a. DATE OF DEATH MONTH DAY YEAR Feb. 20, 1984		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Feb. 21, 1926	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Park Hall, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.		
10. CITY OR TOWN OF DEATH Leonardtowntown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY St. Mary's	13c. CITY OR TOWN Lexington Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Taylor			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavenia Matthews		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Army		16b. SOCIAL SECURITY NO. 219-12-2980	17. INFORMANT ADDRESS Frances H. Taylor Same as 13c		
18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4310 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Hypertension</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 hrs.</u> <u>was</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>James Jarboe</u> attended the deceased from <u>2/20/84</u> to <u>2/20/84</u> , that (I) <u>lost</u> saw the deceased alive on <u>2/20/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.					
22b. SIGNATURE <u>James Jarboe M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/21/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Patrick Jarboe M.D.		22e. ADDRESS Leonardtowntown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 23, '84	23c. NAME OF CEMETERY OR CREMATORY Zion United Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lexington Park St. Mary's Md.
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtowntown, Md.		25a. DATE RECEIVED BY REGISTRAR FEB 24 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rose Mary Williams			2a. DATE OF DEATH MONTH DAY YEAR February 6, 1984			2b. HOUR M					
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 8, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
10 CITY OR TOWN OF DEATH Lexington Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Amber House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Hollywood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 3 Box 492 20636			
14 FATHER'S NAME William Franklin Paddy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Catterton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (SEE NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 219-36-7899A		17 INFORMANT ADDRESS A Vernon Williams same as 13e					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4289 IMMEDIATE CAUSE (a) <u>Coronary Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>1983</u> , 19____, to <u>2/6/84</u> , 19____, that (I) (we) last saw the deceased alive on <u>1/6/84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William D. Boyd</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd M.D.						22e. ADDRESS Leonardtown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 8, '84		23c. NAME OF CEMETERY OR CREMATORY St. John's			23d. LOCATION CITY OR TOWN COUNTY STATE Hollywood St. Mary's Md.			
24 FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Md.						25a. DATE REC'D. BY REGISTRAR FEB 14 1984					
						25b. REGISTRAR'S SIGNATURE <u>Lelia Davidson-Randall</u>					

